The Columbia University Clinic for Anxiety and Related Disorders
Youth Anxiety Center (YAC)

# Background Questionnaire

## To be filled out by Young Adults (18-28 years old)

# BACKGROUND QUESTIONNAIRE

*(To be filled out by parent/main caretaker or patient)*

**Note**: For questions that do not apply to you, please indicate that it is not applicable by witting "N/A" as the answer choice.

**Patient's Name*:** _____ **Patient's Date of Birth*:** _____

**Name of the person filling out the form*:** _____

**Relation to youth:** _____

**Email of person filling out form*:** _____

**Patient's Street Address*:** _____
***City, State, Zip***

_____

***Person to contact in case of emergency (All information is kept confidential: person will only be called in the event of an emergency. Please see limits of confidentiality section of the consent for assessment/treatment form for details):***
***Name:*** _____ ***Phone Number:*** _____

**Family Contact Information**

**Primary parent #1 Name:** _____ **Age:** _____

**Gender:** _____

**Address (if different than patient's):** _____

_____

**Phone:** _____ **Work/Cell Phone:** _____

**Email Address:**_____

**Preferred Method of Contact: __ Phone __ Email __ Both**

**Relationship to Patient: __ Biological Parent __ Adoptive Parent __ Step Parent __ Other**

**Primary parent #2 Name:** _____ **Age:** _____

**Gender:** _____

**Address (if different than patient's):** _____

_____

**Phone:** _____ **Work/Cell Phone:** _____

**Email Address:**_____

**Preferred Method of Contact: __ Phone __ Email __ Both**

**Relationship to Patient: __ Biological Parent __ Adoptive Parent __ Step Parent __ Other**

**Today's date: _____**
*(mm/dd/yyyy)*

**Person Filling Out Form (select one):**

- ○ Parent/main caretaker
- ○ Patient
- ○ Both

**Demographic and Background Information**

**Round the primary language spoken in the home: English Spanish Other: _____**

**Other languages spoken in the home: Other: _____**

**How do you define the patient's ethnicity? _____ Not Latino or Hispanic _____ Latino or Hispanic**

**If Hispanic or Latino (check one):**

_____ Mexican, Mexican American, Chicano
_____ Puerto Rican
_____ Cuban
_____ Dominican
_____ Other Hispanic, Latino, or Spanish origin (for example, print origin: Argentinean, Colombian, Nicaraguan, Salvadorian, Spaniard, etc.): _____

**What is the name of the racial group that <u>best</u> describes the patient?**

_____ White or Caucasian
_____ Black or African-American
_____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian or other Pacific Islander
_____ More than one race; Please specify: _____
_____ Other _____

**If the patient's family practices a religion, specify the patient's religion as a child**: _____

**Does the patient currently identify as religious? _____ Yes _____ No**
**If YES, <u>what religion</u>?** _____

**Patient's Marital Status (check one)**:

____ Single
____ Engaged
____ Married; Date of marriage(s) _____
____ Separated
____ Divorced; If divorced, are you remarried? ____ (Yes/No) If yes, how many times? ____
____ Widowed

**If patient is engaged, married, separated, or divorced:**
Partner's Age: _____ Partner's Gender: _____

Partner's Education Level: _____ Partner's Occupation: _____

Number of Children: _____

If patient has children of their own, what was the age of the patient when first child was born? _____

## Patient's Occupation

**Is the patient currently employed:** _____ **Yes** _____ **No**
**Is the patient currently attending School or College:** _____ **Yes** _____ **No**

**If YES, attending school or college:**

**Name current school or college*:** _____

**Main Office Phone*:** _____

**Placement:** **Private / Parochial / Public / Charter / Boarding / Home studies**

**Current Grade**:
3rd – 4th – 5th – 6th – 7th – 8th – 9th -- 10th – 11th – 12th – GED – College – Masters – PhD

**How many years at current school/college?** _____
(**in years**)

**Teachers Name*:** _____

**Does patient currently receive Special Education services?** ____ **Yes** ____**No**

**If YES, what is his/her service classification?** _____

**Individualized Education Plan (IEP)** ____ **Yes** _____**No**

**504 accommodations** ____ **Yes** _____**No**

**When was the patient's last IEP meeting**? _____
(**mm/dd/yyyy**)

**If don't remember, select one: Last week / Last Month / 2-6 months ago / > 6 months ago**

**Has patient ever received Special Education services in the past?** ____**Yes** ____**No**

**Has patient ever had a 504 or other accommodation?** ____ **Yes** ____**No**

## Family Composition

**List ALL people living in the household:**

| Name | Relationship to Child | Age |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Additional significant family members living outside of the home (living or deceased):**

| Name | Relationship to Child | Age |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Parental occupation**:

**What is primary parent #1's current occupation? _____**

**What is primary parent #2's current occupation? _____**

**Parental education:**

**Please, indicate if parents of patient have completed any of the following educational levels:**

| | Primary Parent #1 | | Primary Parent #2 | |
|---|---|---|---|---|
| **High School** | Yes | No | Yes | No |
| **GED** | Yes | No | Yes | No |
| **College** | Yes | No | Yes | No |
| **Technical or Trade school** | Yes | No | Yes | No |
| **Postgraduate or Professional degree** | Yes | No | Yes | No |

**Relationship between the parents**:

**How would you describe the relationship between the parents/guardians?**

_____

_____

**Current marital status of the parents**:

**(Select only one option)**

| Primary Parent #1 | | Primary Parent #2 | |
|---|---|---|---|
| **1. Never married** | **4. Separated** | **1. Never married** | **4. Separated** |
| **2. Living Together** | **5. Divorced** | **2. Living Together** | **5. Divorced** |
| **3. Married** | **6. Widower/widow** | **3. Married** | **6. Widower/widow** |

**Biological parents ever married to each other**?

**_____Yes _____ No**

**If YES, date of marriage: _____**

**Biological parents ever lived together:**

**_____ Yes _____ No**

**If YES, for how long have parents been living together? _____**
**(in years)**

**One of the biological parents is no longer living in the household or divorced or separated or deceased:**

**_____Yes _____ No**

**If yes, for how long have parents been (separated, divorced, widow/er)? _____**
**(in years)**

**If YES, patient's age when parent's relationship ended: _____**
**(in years)**

**Who has legal custody in terms of physical and mental healthcare?**

| | | |
|---|---|---|
| **Primary Parent #1** | Yes | No |
| **Primary Parent #2** | Yes | No |
| **Other family member who lives with the patient** | Yes | No |
| **An adult who is not a family member but lives with patient** | Yes | No |

**Is the patient legally adopted? _____ No _____ Yes**

**If YES: Age at adoption**: **_____**
**(in years)**

**Is there anyone living in the home with the patient who is a smoker? ____ Yes _____No**

**If YES, who?**

| | | |
|---|---|---|
| **Primary Parent #1** | Yes | No |
| **Primary Parent #2** | Yes | No |
| **Other family member who lives with the patient** | Yes | No |
| **An adult who is not a family member but lives with patient** | Yes | No |

**Brief History of Pregnancy and Infancy**

**What was the primary parent #1's age at child's conception?** _____ (**years)**

**What was the primary parent #2's age at child's conception?** _____ (**years)**

**How many full term pregnancies?** _____

**Which number is this child (1st, 2nd, 3rd, …)?** _____

**Did the mother receive prenatal care for this child?** _____**Yes** ____ **No**

**Length of this child pregnancy:** _____ (**in weeks)**

**Were there any problems during this child pregnancy?** _____**Yes** ____ **No**

**If YES, please describe:**

_____

_____

**During this child pregnancy did you take any of the following?** **If YES, which ones?**

| | | | |
|---|---|---|---|
| **Prescription medications** | **Yes** | **No** | _____ |
| **Over-the-counter drugs** | **Yes** | **No** | _____ |
| **Vitamins/dietary supplements** | **Yes** | **No** | _____ |

**Were cigarettes smoked in the home during this child pregnancy?** _____**Yes** ____ **No**

**If Yes, how many cigarettes on average per day?**
_____ 0-5
_____ 6-10
_____ 11-20
_____ +20

**Can you tell us the weight and the length of your child at birth?**
**Specify the weight**: _____ pounds _____kilos _____ Don't remember

**Specify length:** _____inches _____cm _____ Don't remember

**Were there any complications associated with this child delivery?** _____**Yes** ____ **No**

**If any complications, specify below:**

**Was this child premature?** _____**Yes** ____ **No**

**If YES, with how many weeks of pregnancy was he/she born? _____ weeks**

**Type of delivery: ___ Vaginal ____ C-Section (please describe reason):**

_____

**Did the child require any special or intensive care post-delivery? ____Yes _____No**

**If YES, please describe**: _____

_____

**Was this child born with low weight? _____Yes ____ No**

**Other complications? _____Yes ____ No**

**If YES, please describe**: _____

_____

**Were there any feeding problems? If yes, please describe:**

_____

**Were there any sleeping problems: If yes, please describe:**

_____

**As an infant, was your child a difficult baby: ___ yes ___ no**

**As an infant, did your child like to held: ___ yes ___ no**

**As an infant, was your child alert: ___ yes ___ no**

**Developmental Milestones of Child**

**Please indicate the age (in months) at which your child first demonstrated the following behaviors.**

| | Months | | Months |
|---|---|---|---|
| **Crawled** | _____ | **Babbled** | _____ |
| **Stood alone** | _____ | **Spoke first word** | _____ |
| **Walked alone** | _____ | **Spoke 2-3-word phrase** | _____ |
| **Stayed dry at night** | _____ | **Spoke complete sentence** | _____ |
| **Toilet trained** | _____ | **Fed self** | _____ |
| **Dressed self** | _____ | **Ran** | _____ |

**Tied shoes** _____ **Rode a tricycle** _____

**Any developmental delay?** _____**Yes** ____ **No**

| | | |
|---|---|---|
| **Language** | **Yes** | **No** |
| **Motor, Physical** | **Yes** | **No** |
| **Learning** | **Yes** | **No** |
| **Other** | **Yes** | **No** |

**If any <u>other</u> delay, please describe**:

_____

_____

**Educational History of the Patient**

**Has patient ever had neuropsychological testing? If yes, when and by whom?**
(Please bring copies to your assessment):

_____

_____

**Has patient ever been diagnosed with a learning disability? If yes, what type and when:**

_____

_____

**Ever repeated or failed a grade:** ____ **Yes** ___**No**

**If patient has been HELD BACK:**

**How many times has patient been held back and why (grades, absences)?**

**|**__**|**__**|** TIMES **|**__**|**__**|** GRADE <u>last time</u> held back

**Reason (why?)**: _____

_____

_____

**Please place a check next to any problem that patient currently exhibits (or caused difficulty in the past):**

____ **Difficulty with reading**
____ **Difficulty with spelling**
____ **Difficulty with writing**
____ **Difficulty with arithmetic**
____ **Difficulty with other subjects (please list):** _____
____ **Dislike school**

**Current School Performance (<u>check one</u>):**

**Failing** _____
**Below Average** _____
**Average** _____
**Above Average** _____

**Do you feel that your child/patient is properly placed in the current school/classroom: Yes** ___ **No** ___

**If no, please explain your concern with the current placement:** _____

_____

_____

**Psychiatric History of the Patient**

**Please indicate any illness or condition that the patient has had and their age at the time:**

| **Patient Psychiatric History:** | **Select one:** | **Age diagnosed:** |
|---|---|---|
| Depressive Disorder | __ Yes __ No | _____ years |
| Anxiety Disorder | __ Yes __ No | _____ years |
| ADHD | __ Yes __ No | _____ years |
| Obsessive Compulsive Disorder | __ Yes __ No | _____ years |
| Eating Disorders | __ Yes __ No | _____ years |
| Tourette's, Other Tic Disorder | __ Yes __ No | _____ years |
| Asperger's, Autism, POD | __ Yes __ No | _____ years |
| Other: _____ | __ Yes __ No | _____ years |

***Has patient ever witnessed or experienced physical abuse?*** ____*Yes* ____*No*

***Has patient ever witnessed or experienced domestic violence?*** ____ *Yes* ____ *No*

***Has patient ever witnessed or experienced sexual abuse?*** ____ *Yes* ____ *No*

***Has patient ever witnessed or experienced emotional abuse?*** ____ *Yes* ____ *No*

***Has patient ever witnessed or experienced a traumatic event?*** ____ *Yes* ____ *No*

***Have any friends or acquaintances of the patient made a suicide attempt?*** ____ *Yes* ____ *No*

***If YES to any above questions, please explain:*** _____

_____

**Has the patient ever received any kind of services and/or counseling outside of school?** ____**Yes** ___**No**

**If patient ever received services and/or counseling, what type of Service (i.e., psychiatry, psychology, counselor): ___ Yes ___ No**

**Doctor, Psychiatrist** **Yes** **No**

**Psychologist, Therapist** **Yes** **No**

**Counselor** **Yes** **No**

**Provider's name*:** _____

**Diagnosis:** _____

**Contact Number*:** _____

**Length of treatment:** **< 1 month** **1-6 months** **6 months-2 years** **2-5 years** **+ 5 years**

**If any other services, what type of Service (i.e., psychiatry, psychology, counseling): ____ Yes ____No**

**Doctor, Psychiatrist** **Yes** **No**

**Psychologist, Therapist** **Yes** **No**

**Counselor** **Yes** **No**

**Provider's name*:** _____

**Diagnosis:** _____

**Contact Number*:** _____

**Length of treatment:** **< 1 month** **1-6 months** **6 months-2 years** **2-5 years** **+ 5 years**

**Has the patient ever received treatment from any of the following Youth Anxiety Center (YAC) clinics? (Check all that apply):**

**_____ Washington Heights Clinic at Presbyterian Hospital**

**_____ CUCARD – Columbus Circle**

**_____ Weill Cornell Medical Center**

- **Outpatient Department**
- **Partial Hospitalization Program**
- **Don't know**

**____ Don't know / Refuse**

**____ Not applicable / Did not receive treatment there**

**Psychiatric Hospitalizations: ____Yes _____ No**

**If YES: How many times? _____**

**What was the reason? _____**

_____

_____

***Indicate the medications the patient is <u>currently</u> receiving:***

| | | |
|---|---|---|
| **Prescription medications** | **Yes** | **No** |
| **Over-the-counter drugs** | **Yes** | **No** |
| **Vitamins, dietary supplements** | **Yes** | **No** |

| **List the medicaments** | **Dosage** (**mg/day, number tablets**) | **Date started** (**mm/dd/yyyy**) | **Taken consistently?** |
|---|---|---|---|
| _____ | _____ | _____ | **Yes** **No** |
| _____ | _____ | _____ | **Yes** **No** |
| _____ | _____ | _____ | **Yes** **No** |
| _____ | _____ | _____ | **Yes** **No** |
| _____ | _____ | _____ | **Yes** **No** |

**Other relevant mental health treatment information:** _____

_____

_____

**Medical History of the Patient**

| **Patient Medical History:** | **Age of Onset:** | **Dates:** |
|---|---|---|
| **Allergies** | | |
| __ Food Allergies (Describe): _____ | _____ | _____ |
| __ Hay Fever | _____ | _____ |
| __ Household Allergies | _____ | _____ |
| __ Other (Describe): _____ | _____ | _____ |
| **Blood Disorders** | | |
| __ Anemia | _____ | _____ |
| __ Hemophilia | _____ | _____ |
| __ Bleeding Problems | _____ | _____ |
| __ Other (Describe): _____ | _____ | _____ |
| **Dermatological** | | |
| __ Acne | _____ | _____ |
| __ Eczema | _____ | _____ |
| __ Psoriasis | _____ | _____ |
| __ Hives | _____ | _____ |
| __ Other (Describe): _____ | _____ | _____ |
| **Cardiovascular/Pulmonary** | | |
| __ Heart Disease (Describe): _____ | _____ | _____ |

__ High/Low Blood Pressure _____ _____
__ Mitral Valve prolapse _____ _____
__ Irregular Heart Beat _____ _____ _____
__ Asthma _____ _____
__ Cystic Fibrosis _____ _____
__ Hyperventilation _____ _____
__ Other (Describe): _____ _____ _____

**Conditions of Childhood**

__ Chicken Pox _____ _____
__ Diphtheria _____ _____
__ German Measles _____ _____
__ Measles _____ _____
__ Mumps _____ _____
__ Whooping Cough _____ _____
__ Stuttering _____ _____
__ Other (Describe): _____ _____ _____

**Endocrine**

__ Thyroid Condition _____ _____
__ Diabetes: __ Type I __Type II _____ _____
__ Other (Describe): _____ _____ _____

**Eye, Ear, Throat**

__ Impaired Vision _____ _____
__ Impaired Hearing _____ _____
__ Frequent Earaches _____ _____
__ Ear Tubes _____ _____
__ Frequent Sore Throats/Colds _____ _____
__ Strep Infection _____ _____
__ Other (Describe): _____ _____ _____

**Gastrointestinal**

__ Stomachaches _____ _____
__ Constipation _____ _____
__ Diarrhea _____ _____
__ Soils Self _____ _____
__ Reflux _____ _____
__ Irritable Bowel Syndrome _____ _____
__ Crohn's Disease _____ _____
__ Other (Describe): _____ _____ _____
Any foods that you avoid? _____

**Genitourinary**

__ Urinary Tract Infections _____ _____
__ Kidney Problems _____ _____
__ Enuresis (Wetting) __ Day __ Night _____ _____
__ Other (Describe) _____ _____ _____

**Joints and Muscles**

__ Arthritis _____ _____
__ Broken Bones _____ _____
__ Bone or Joint Disease _____ _____
__ Other (Describe): _____ _____ _____

**Neurological**

__ Head Trauma/Injury (Describe): _____ _____ _____
__ Frequent or Severe Headaches _____ _____
__ Epilepsy _____ _____
__ Seizure/Other Seizure Disorder _____ _____
__ Tics _____ _____
__ Fainting Spells/Dizziness _____ _____
__ Loss of Consciousness _____ _____
__ Paralysis _____ _____
__ Other (Describe): _____ _____ _____

**Reproductive**

__ First Period _____ _____
__ Premenstrual Syndrome/Problems _____ _____
__ Irregular Cycle _____ _____
__ Other (Describe): _____ _____ _____

**Other**

__ Hospitalizations (Describe): _____ _____ _____
__ Surgeries (Describe): _____ _____ _____
__ Emergency Room Visit (Describe):_____ _____ _____
__ Cancer (Describe): _____ _____ _____
__ Meningitis _____ _____
__ Convulsions _____ _____
__ Other _____ _____

**Has patient been hospitalized for medical reasons?** ____ **Yes** ____ **No**

**Has patient had any operations?** ____ **Yes** ____ **No**

**Has patient had any accidents?** ____ **Yes** ____ **No**

**Has patient ever experienced a loss of consciousness?** ____ **Yes** ____ **No**

**If YES to any above questions, please explain**: _____

_____

_____

_____

**Is there any other important thing about the patient that you would like to tell us?** ___ **Yes** ____**No**

**If YES, please explain:** _____

_____

_____

**Family Medical and Mental Health History**

**Please describe <u>any family history</u> of medical conditions:**

| **Medical illness** | **Select one** | | **If YES, Relation to child** |
|---|---|---|---|
| **Cancer** | **Yes** | **No** | **____ Immediate family (parent #1, parent #2, sibling)**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Diabetes** | **Yes** | **No** | **____ Immediate family (parent #1, parent #2, sibling)**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Cardiovascular Problems** | **Yes** | **No** | **____ Immediate family (parent #1, parent #2, sibling)**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Neurological Problems** | **Yes** | **No** | **____ Immediate family (parent #1, parent #2, sibling)**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Other:** _____<br>_____<br>_____<br>_____ | **Yes** | **No** | **____ Immediate family (parent #1, parent #2, sibling)**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |

**Please describe <u>any family history</u> of psychiatric/psychological and behavioral problems:**

| **Mental health problems** | **Select one** | | **If YES, specify relation to child** |
|---|---|---|---|
| **Depression** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Bipolar Disorder** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Anxiety** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |

| | | | |
|---|---|---|---|
| **Obsessive Compulsive Disorder** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Panic Attacks** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Learning Problems** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Behavior Problems** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **ADHD/ADD** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Autism/Asperger's** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Schizophrenia** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Mental Retardation** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Suicide Attempts** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Alcoholism** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |

| | | | |
|---|---|---|---|
| **Drug Addiction** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Legal Problems** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |
| **Other: _____** | **Yes** | **No** | **____ Primary Parent #1**<br>**____ Primary Parent #2**<br>**____ Siblings**<br>**____ Other family member (grandparent, aunt, cousin, etc.)** |

**Presenting Problem**

**Briefly describe your current difficulties:**

**When did this problem first become a concern to you?**

_____

_____

**When was the problem first noticed?**

_____

_____

**What seems to make the problem worse?**

_____

_____